MassHealth

Billing Guide for the UB-04 Paper Claim Form

Executive Office of Health and Human Services
MassHealth
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BG-UB-CL (07/07)

Table of Contents

Introduction

The following information describes in detail how to bill on the UB-04 claim form. For administrative and billing instructions, see Subchapter 5 of your MassHealth provider manual.

For information about the resulting remittance advice, see the Guide to Remittance Advice and Electronic Equivalents for the UB-04.

General Instructions for Submitting Paper Claims

UB-04 Claim Form

The following providers must use the UB-04 when submitting paper claims to MassHealth:

- acute inpatient hospitals;
- acute outpatient hospitals;
- chronic disease and rehabilitation inpatient hospitals;
- chronic disease and rehabilitation outpatient hospitals;
- intensive residential treatment programs;
- psychiatric inpatient hospitals;
- psychiatric outpatient hospitals;
- semi-acute inpatient hospitals; and
- semi-acute outpatient hospitals;

Additional Details

Up to 22 revenue codes and associated charges may be entered on each UB-04 claim form. If there are more than 22 lines (plus the line for Revenue Code 001 Total Charges), submit the claim electronically.

Entering Information on the UB-04 Claim Form

- Complete a separate claim form for each member to whom services were provided.
- Type or print all applicable information (as stated in the instructions) on the claim form, using black ink only. Be sure all entries are complete, accurate, and legible.
- For each claim line, enter all required information as applicable, repeating if necessary. Do not use ditto marks or words such as "same as above."
- Attach any necessary reports or required forms to the claim form.
- Use only line "A" within a given item on the UB-04, unless otherwise specified.
- When a required entry is a date, enter the date in MMDDYY format.

  Example: For a member born on February 28, 1960, the entry in Item 10 (Birthdate) would be as follows.

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General Instructions for Submitting Paper Claims (cont.)

Time Limitations on the Submission of Claims

The period fixed by statute (M.G.L. c. 118E, § 38) for the submission of claims is 90 days, measured from the date of service or the date on the explanation of benefits (EOB) for another insurer to the date on which the claim form is received by MassHealth. For regulations governing time limitations on the submission of claims, see the administrative and billing regulations in your MassHealth provider manual.

All services listed on a single claim must have been provided in the same fiscal year. If a claim billed for a stay spans state fiscal years (June 30 to July 1), you must bill the appropriate interim claim for each fiscal year. For additional information about submitting claims, consult the administrative and billing instructions in Subchapter 5 of your MassHealth provider manual.

Claims for Members with Other Health Insurance Coverage

Special instructions for submitting claims for services furnished to members with health insurance coverage are contained in Subchapter 5 of your MassHealth provider manual.

Electronic Claims

To submit electronic claims, contact MassHealth Customer Service. Refer to Appendix A of your provider manual for contact information. Additional information is available in Subchapter 5 of your provider manual.

Where to Send Paper Claim Forms

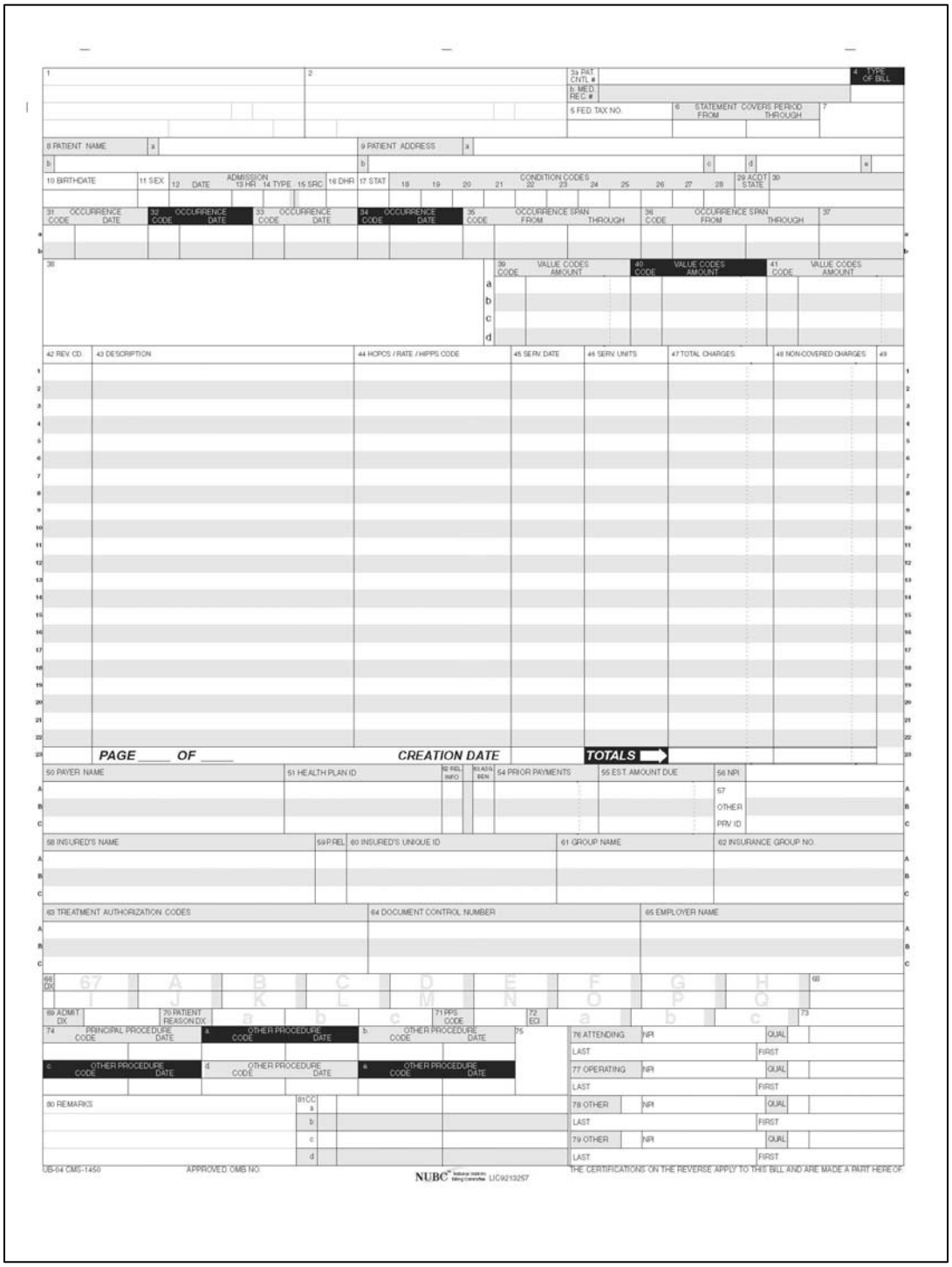
Appendix A of your MassHealth provider manual describes where to submit paper claims. Keep a copy of the submitted claim for your records. Please note that MassHealth does not accept mail with postage due.

Further Assistance

If, after reviewing the following item-by-item instructions, you need additional assistance to complete the UB-04 claim form, you can contact MassHealth Customer Service. Please refer to Appendix A for all MassHealth Customer Service contact information.

Item-by-Item Instructions for the UB-04 Claim Form

This section contains instructions for completing the UB-04 claim form for inpatient and outpatient hospital services provided to MassHealth members. Code sets for each item on the UB-04 are provided in a separate section beginning on page 20. A sample claim form is shown below.



Item-by-Item Instructions for the UB-04 Claim Form (cont.)

Item No.	Item Name	Description
1		Enter the provider's name, address, city, state, and zip code.
2		Leave this item blank.
3a	Pat Cntl #	Enter the patient control number, if one is assigned. If one is not assigned, enter the member's last name.
3b	Med. Rec. #	Enter the medical record number.
4	Type of Bill	Enter the three-digit code to indicate the type of bill. See code sets for type of bill on page 19.
5	Fed. Tax No.	Leave this item blank.
6	Statement Covers Period From/Through	Enter the date the service was provided in MMDDYY format. *Inpatient Hospitals* If the member was admitted and discharged on the same date, enter that date in both the "From" and "Through" fields. For patients billed with a discharge patient status, use the date of discharge to home or facility in the "Through" field. Bill for consecutive dates of service only. *Outpatient Hospitals* Use a separate claim form for each date of service.
7		Enter the total number of covered days represented in the "From" and "Through" dates in Item 6. Do not count the "Through" date as a covered day for claims with a discharge or deceased patient status code.
8a	Patient Name	Leave this item blank.
8b	Patient Name	Leave this item blank.
9a	Patient Address	Leave this item blank.
9b	Patient Address	Leave this item blank.
9c	Patient Address	Leave this item blank.
9d	Patient Address	Leave this item blank.
9e	Patient Address	Leave this item blank.
10	Birthdate	Enter the member's date of birth in MMDDYY format.

Item-by-Item Instructions for the UB-04 Claim Form (cont.)

Item No.	Item Name	Description
11	Sex	Enter an "M" or "F" to indicate the member's gender.
12	Admission Date	Enter the date the member was admitted for care in MMDDYY format.
13	Admission Hour	Enter the two-digit code that corresponds to the hour the member was admitted for services on the date entered in Item 12. See code sets for admission/discharge hour on page 20.
14	Admission Type	Enter the code to indicate the priority of the admission. See code sets for admission type on page 20. If billing for more than one visit on a single date of service, enter the code that describes the priority of the first visit.
15	Admission SRC	Enter the code to indicate the source of the admission. See code sets for admission source on page 20. If the entry in Item 14 is "4," use the applicable newborn code.
16	DHR	Enter the two-digit code that corresponds to the hour the member was discharged on the "Through" date entered in Item 6. See code sets for admission/discharge hour on page 20.
17	Stat	Enter the code to indicate the member's status on the "Through" date in Item 6, if applicable. See code sets for patient status on page 21.
18-22	Condition Codes	Enter the condition code from the list beginning on page 21 that describes the member's special circumstances, if applicable. If more than one code applies, enter the numerically lower one first.
23-28	Condition Codes	Leave this item blank.
29	ACDT State	Leave this item blank.
30		Leave this item blank.
31-34	Occurrence Code/Date	If the service was necessary because the member was involved in an accident, enter in the "Code" field the occurrence code from the list beginning on page 22 that describes the type of accident. Enter the date the accident occurred in MMDDYY format.
35a	Occurrence Span From/Through	Leave this item blank.

Item-by-Item Instructions for the UB-04 Claim Form (cont.)

Item No.	Item Name	Description
35b	Occurrence Span From/Through	Leave this item blank.
36a	Occurrence Span From/Through	Leave this item blank.
36b	Occurrence Span From/Through	Leave this item blank.
37		Leave this item blank unless otherwise noted.
38		Leave this item blank.
39a	Value Codes Code/Amount	Enter one value code and the corresponding assigned payment amount or rate. See code sets for value codes on page 23.
39b-d	Value Codes Code/Amount	Leave this item blank.
40a	Value Codes Code/Amount	Leave this item blank unless otherwise noted. *Acute Inpatient Hospitals* If the member has a deductible requirement, enter the applicable value code in the "Code" field and enter the deductible amount in the "Amount" field. See code sets for value codes on page 23. *Chronic Disease and Rehabilitation Hospitals* Enter the appropriate patient-paid amount, including deductible as applicable in the "Amount" field.
40b-d	Value Codes Code/Amount	Leave this item blank.
41a-d	Value Codes Code/Amount	Leave this item blank.

Item-by-Item Instructions for the UB-04 Claim Form (cont.)

Item No.	Item Name	Description
42 (lines 1-22)	Rev. Cd	Enter the three-digit revenue code to identify the accommodations and services provided. See code sets for revenue codes beginning on page 24. All ancillary services, including services covered by Medicare (Part B) and physician services and charges, must be listed in this item. The estimated Medicare payment and coinsurance amount for the Medicare (Part B) ancillary covered services must be totaled and the sum entered in Item 54. This amount must equal the Medicare reimbursement rate and will be deducted from the MassHealth payment. *Acute Inpatient and Psychiatric Inpatient Hospitals* If the member occupied more than one type of bed accommodation on the same day, enter for that day only the revenue code for the last bed accommodation to which the member was transferred. *All Inpatient Hospitals* Do not include revenue codes for room-and-board charges incurred on the day of discharge, unless the member was admitted and discharged on the same day
42 (line 23)	Rev Cd.	Enter revenue code "001."
43 (lines 1-22)	Description	Leave this item blank unless otherwise noted. *Chronic Disease and Rehabilitation Inpatient Hospitals* If providing physical, occupational, or speech therapy to a Medicare member and the therapy is deemed to be maintenance therapy by Medicare, briefly describe the service and enter "M" next to the description. Do not include charges for these services in the amount entered in the prior-payments field (Item 54), as the facility does not receive Medicare reimbursement for these services.
43 (line 23)	Page__of__	Leave this item blank.

Item-by-Item Instructions for the UB-04 Claim Form (cont.)

Item No.	Item Name	Description
44 (lines 1-22)	HCPCS/Rates/HIPPS Code	Leave this item blank unless otherwise noted. *Acute Outpatient Hospitals* *In-state Acute Outpatient Hospitals and Hospital-Licensed Health Centers* If revenue code entered in Item 42 requires a HCPCS code, enter the five-digit HCPCS code. Refer to Appendix F of the *Acute Outpatient Hospital Manual* for the list of revenue codes that require HCPCS codes. For certain types of services, a two-character modifier must be entered after the service code to fully describe services. If applicable, enter the two-digit HCPCS modifier to fully describe the services provided. *For Out-of-State and Chronic Disease and Rehabilitation Outpatient Departments* Enter an applicable HCPCS code for each revenue code entered in Lines 1-22 in Item 42. For certain types of services, a two-character modifier must be entered after the service code to fully describe services. If applicable, enter the two-digit HCPCS modifier to fully describe the services provided.
45 (lines 1-22)	Serv. Date	Leave this item blank.
45 (line 23)	Creation Date	Enter the date the claim form was submitted for reimbursement. This date cannot be earlier than the service dates billed on the claim form.
46 (lines 1-22)	Serv. Units	Enter the number of units of services provided. See code sets for units of service on page 31, to determine the appropriate units for the corresponding revenue codes. *Acute Inpatient, Chronic Disease and Rehabilitation Impatient and Psychiatric Inpatient Hospitals* The total number of units of service for all room-and-board charges must equal the number entered in Item 7.
47 (lines 1-22)	Total Charges	For each claim line, enter the total charges that apply to the revenue code entered in lines 1-22 in Item 42. Do not deduct the member's copayment amount from the total charge of the claim.

Item-by-Item Instructions for the UB-04 Claim Form (cont.)

Item No.	Item Name	Description
47 (line 23)	Total Charges (Totals)	Enter the total of all entries in this column on the bottom line.
48 (lines 1-22)	Non-Covered Charges	Leave this item blank.
48 (line 23)	Non-Covered Charges (Totals)	Leave this item blank.
49 (lines 1-23)		Leave this item blank.
50A	Payer Name (Primary)	Leave this item blank.
50B	Payer Name (Secondary)	Leave this item blank.
50C	Payer Name (Tertiary)	Leave this item blank.
51A-C	Health Plan ID	Leave this item blank.
52A-C	Rel Info	Leave this item blank.
53A-C	Asg. Ben.	Leave this item blank.
54A-C	Prior Payments	Leave this item blank unless the member has other health-insurance coverage. Do not enter previous MassHealth payments. Enter any amount received toward the payment of services on this claim form from any source other than MassHealth, and attach a copy of the explanation of benefits from the other payer to the claim form. Any amount entered in Item 54 will be deducted from the MassHealth payment. *Acute Inpatient Hospitals* *Medicare Part B When Part A Is Exhausted or Partially Covered* Enter the sum of the Medicare payment, coinsurance, and deductible amount for the covered Medicare Part B ancillary and physician services. This amount will be deducted from the MassHealth payment. These claims must be submitted within 90 days of the date of the most recent Explanation of Medicare Benefits (EOMB)

Item-by-Item Instructions for the UB-04 Claim Form (cont.)

Item No.	Item Name	Description
54A-C (cont.)	Prior Payments (cont.)	*Chronic Disease and Rehabilitation Inpatient Hospitals* *For Hospitals Subject to the Per-Diem Reimbursement Methodology* Enter the total estimated Medicare payment and co-insurance amount for the Medicare (Part B) ancillary covered services. This amount must equal the Medicare reimbursement rate and will be deducted from the MassHealth payment.
55A-C	Est. Amount Due	Leave this item blank.
56	NPI	Enter provider's 10-digit national provider identifier (NPI).
57A-C	Other Prv. ID	Leave this item blank.
58A-C	Insured's Name	Leave this item blank.
59A-C	P. Rel	If applicable, if this claim is submitted for care provided to a patient who is not a MassHealth member but is donating an organ to a MassHealth member, enter "11."
60A-C	Insured's Unique ID	Enter the complete 10-character member identification number that is printed on the MassHealth card below or beside the member's name. The member identification number on the temporary MassHealth card may include an asterisk as the 10th character. *Acute Inpatient Hospitals* Use separate claim forms for a mother and her newborn. Do not submit claims for services to the newborn on the mother's claim form. Do not use the mother's member ID number for the newborn; a separate member ID number assigned to the newborn must be used. See the Additional Instructions section for an explanation of billing for a newborn on page 18. *Acute Inpatient and Acute Outpatient Hospitals* For organ-donor claims in which the donor is not a MassHealth member, enter the RID of the member receiving the organ, and enter a patient control number in Item 3a.
61A-C	Group Name	Leave this item blank.
62A-C	Insurance Group No.	Leave this item blank.

Item-by-Item Instructions for the UB-04 Claim Form (cont.)

Item No.	Item Name	Description
63A-C	Treatment Authorization Codes	Leave this item blank unless otherwise noted. *Acute Inpatient and Chronic Disease and Rehabilitation Hospitals* On line "A," enter the six-digit preadmission screening (PAS) or concurrent review number assigned to the hospital stay, if applicable. *Acute Outpatient Hospitals* When claims for nonemergent services are provided in an outpatient hospital to PCC Plan enrollees, enter the PCC's seven-digit referral number.
64A	Document Control No. (Line A only)	Adjustment. When requesting an adjustment to a paid claim, enter an "A" followed by the 10-character transaction control number (TCN) assigned to the paid claim. This TCN appears on the remittance advice on which the original claim was paid. Resubmittal, When resubmitting a claim as outlined in Subchapter 5, Part 7 of your MassHealth provider manual, enter an "R" followed by the 10-character TCN assigned to the denied claim. This TCN appears on the remittance advice on which the original claim was denied.
64B-C	Document Control No.	Leave this item blank.
65	Employer Name	Leave this item blank.
66	DX	Leave this item blank.
67	Prin. Diag. Cd.	Enter the ICD-9-CM diagnosis code. If there is a fourth or fifth digit, it is a required part of the code. Do not delete leading zeros or add trailing zeros. Do not use decimal points. "V" codes are acceptable. "E" or "M" codes are not acceptable. Do not include present-on-admission (POA) indicators in this field.
67 (A-Q)	Other Diag. Cd.	Enter the ICD-9-CM diagnosis code for any additional condition that has been treated, if applicable. "V," "E," and "M" codes are acceptable. Do not include POA indicators in this field
68		Leave this item blank.
69	Admit DX	Leave this item blank.
70(a-c)	Patient Reason DX	Leave this item blank.

Item-by-Item Instructions for the UB-04 Claim Form (cont.)

Item No.	Item Name	Description
71	PPS Code	Leave this item blank.
72(a-c)	ECI	Leave this item blank.
73	(Unlabeled)	Leave this item blank.
74	Principal Procedure Code/Date	Leave this item blank unless otherwise noted. *Acute Inpatient, Acute Outpatient, and Chronic Disease and Rehabilitation Inpatient Hospitals* If a surgical or obstetrical procedure was performed, enter the most specific ICD-9-CM procedure code that identifies the procedure in the "Code" field. In the "Date" field, enter the date the procedure was performed in MMDDYY format. Also complete Item 77.
74 (a-e)	Other Procedures	Leave this item blank unless otherwise noted. *Acute Inpatient, Acute Outpatient, and Chronic Disease and Rehabilitation Inpatient Hospitals* If other surgical or obstetrical procedures were performed, enter the most specific ICD-9-CM procedure code that identifies the procedure in the "Code" field. In the "Date" field, enter the date the procedure was performed in MMDDYY format. Also complete Item 77.
75		Leave this item blank.
76	Attending NPI/Qual	Enter the NPI of the physician who is primarily responsible for the care of the patient during this hospitalization.
	Attending Last/First	Enter the name of the physician who is identified above.
77	Operating NPI/Qual	Enter the NPI of the provider who performed the service listed in Item 74, if applicable.
	Operating Last/First	Enter the name of the provider who is identified above, if applicable.
78	Other NPI/Qual	Enter the NPI of any additional provider who performed the service, if applicable.
	Other Last/First	Enter the name of the provider who is identified above, if applicable.

Item-by-Item Instructions for the UB-04 Claim Form (cont.)

Item No.	Item Name	Description
79	Other NPI/Qual	Enter the NPI of any additional provider who performed the service, if applicable.
	Other Last/First	Enter the name of the provider who is identified above, if applicable.
80	Remarks	Leave this item blank.
81a	CC	Enter the taxonomy code applicable for the NPI listed in Item 56 only if instructed to do so by MassHealth.
81b	CC	Enter the taxonomy code applicable for the NPI listed in Item 76, if applicable, and only if instructed to do so by MassHealth.
81c	CC	Enter the taxonomy code applicable for the NPI listed in Item 77, if applicable, and only if instructed to do so by MassHealth.
81d	CC	Leave this item blank.

Additional Instructions

Acute Inpatient Hospitals

Payment Methodology for In-State Acute Inpatient Hospitals

The payment methodology for in-state acute admissions on and after November 22, 1991, requires the billing of various components of a hospital stay on separate claim forms. Each component of a stay is identified by a value code. Value codes are published on page 24. Components of stay are defined as follows.

Standard Payment Amount per Discharge

MassHealth pays in-state acute hospital claims with dates of admission on and after November 22, 1991, a Standard Payment Amount per Discharge (SPAD) for the first 20 covered acute days of a hospital stay, including substance abuse treatment for non-Managed Care members. Pediatric hospitals and hospitals with a specialized pediatric unit may have been assigned a Pediatric SPAD.

A maximum of one SPAD will be paid for the first 20 acute days of a stay, even if the acute days are not consecutive.

Outlier per Diem

Outlier days must be billed on a separate claim form when the length of stay at an acute status exceeds 20 days, and the patient has not been admitted to a discrete psychiatric unit for which a separate payment has been established. Outlier days are also allowed after the member has been transferred from an administrative day (AD) status to an acute status, and the cumulative number of acute days after the SPAD exceeds 20.

Administrative per Diem

Administrative days (AD) must be billed on a separate claim form when the Utilization Review Department at the hospital determines that a member's care needs can be provided in a setting other than an acute inpatient hospital and when a member is clinically ready for discharge.

Transfer per Diem

A hospital must bill for a transfer per diem on a separate claim form when any of the following conditions are met.

- A member in an acute status is transferred to another acute facility;
- A member for whom a SPAD has never been billed is transferred from an AD status to an acute status within the same facility;
- a member is transferred from a discrete psychiatric unit within the same facility;
- a member's managed-care status changes during a psychiatric or substance abuse treatment stay;
- a member's claim in an acute status becomes payable because other insurance benefits have been exhausted; or
- a member is admitted as an inpatient after ambulatory surgery or outpatient procedure.

The transfer component of the stay will be paid a per diem amount, cumulatively reimbursable up to, but not in excess of, the SPAD. A maximum of one transfer component of stay will be paid per facility per hospitalization. Outlier claims may be billed after the member has stayed a total of 20 acute days as a transfer. These days need not be consecutive.

Additional Instructions (cont.)

Acute Zero-Payment per Diem

Effective for dates of admission on and after October 1, 1992, a hospital must bill for a zero-payment component of stay using the acute zero-payment per diem value code on a separate claim form when all of the following conditions are met.

- a member's status has changed from AD to acute;
- a standard payment amount per discharge (SPAD) or transfer per diem has already been billed; and
- the cumulative number of acute days, beginning with the first day of the SPAD or the transfer component of stay, is less than 20.

Psychiatric per Diem

Effective for dates of admission on and after October 1, 1992, a hospital must bill the psychiatric per diem value code if the member has been admitted to a psychiatric unit licensed by the Department of Mental Health for which a separate payment has been established, and if the patient is a non-managed-care member. The hospital must not bill for a SPAD, instead of, or in addition to, the psychiatric per diem. When the member's status changes between psychiatric and acute, the acute component of the stay must be billed on a separate claim form using the transfer per diem value code.

Late Charges

Late charges must be billed on a separate claim form if they occur, and will be reimbursed as a zero payment due to the SPAD pricing methodology. Enter on the late-charge claim form the same information that appeared on the original claim except for Items 4, 42, 43, 44, 46, 47, and 54. Enter "115" in Item 4. Items 42, 43, 44, 46, 47, and 54 should reflect only the charges that were not billed originally. A late-charge claim must reflect only one date of service, and is subject to the 90-day billing deadline from that date. Send the late charge claim form directly to MassHealth for processing.

Professional Services

MassHealth pays hospitals for professional services provided by a hospital-based physician at the most current physician fee schedule established by the Division of Health Care Finance and Policy at 114.3 CMR 16.00, 17.00, 18.00, and 20.00, when those services are billed on the physician claim form no. 5.

Only services provided by a hospital-based physician may be billed on claim form no. 5 by the hospital. Payment for services provided by other professionals is included in the facility payment (for example, SPAD, outlier, or AD).

Organ Transplant Claims

MassHealth covers organ transplant-related services provided to a donor who gives an organ to a MassHealth member. Use separate claim forms to bill for the services provided to the organ donor and the member. When billing for the donor's care, please use the member's name and member identification number, and enter "11" in Item 59 on the donor's claim.

Inpatient and Outpatient Services Provided on the Same Day

Special instructions apply to circumstances where the member receives inpatient and outpatient care on the same day. See these instructions in the Acute Inpatient and Acute Outpatient Services Provided on the Same Day section on page 17.

Additional Instructions (cont.)

Acute Outpatient Hospitals

Professional Services Performed by Hospital-Based Physicians

If the hospital is billing for professional services performed by hospital-based physicians in the outpatient department, an approved hospital satellite as defined in the RFA, or a hospital-licensed health center, the hospital must bill using claim form no. 5 or its electronic equivalent.

Laboratory Services

Laboratory services provided by in-state acute outpatient hospitals, an approved satellite as defined in the RFA, and hospital-licensed health centers are paid according to the Division of Health Care Finance and Policy (DHCFP) independent clinical laboratory fee schedule, based on the HCPCS code entered on the UB-04. Certain surgical pathology codes are paid according to the payment amount per episode (PAPE) methodology.

Out-of-State Facilities

Out-of-state facilities are paid according to the Medicaid regulations of the state in which the facility is located.

Ancillary Services

Ancillary services (other than laboratory services) provided by in-state acute outpatient hospitals, an approved hospital satellite as defined in the RFA, and hospital-licensed health centers are paid by PAPE.

Ancillary services provided by out-of-state outpatient hospitals and non-acute in-state outpatient hospitals are paid according to the MassHealth regulations.

Copayment Requirements

In certain cases, a copayment of $3.00 is required from members. When appropriate, the copayment will automatically be subtracted from the MassHealth payment of the facility charge. Providers should not subtract the copayment amount from the total facility charge, or indicate anywhere on the claim form the amount paid by the member. The decision to subtract a copayment is made by MassHealth based on the information on the claim form and in the member's file. Refer to the regulations at 130 CMR 450.130 for more information about copayments.

Services Provided to Members Restricted to a Primary Care Clinician

Many members are (or will be) enrolled with a primary care clinician, as part of MassHealth's Managed Care Program. All care, except for those services identified in 130 CMR 450.118(J), must be provided or authorized by the member's PCC. Refer to 130 CMR 450.118 for a full explanation of the Managed Care Program. Refer to Item 63 in the item-by-item instructions for details on completing the claim form for authorized services.

Additional Instructions (cont.)

Billing for Behavioral Health Services for Managed Care Members

All members who meet MassHealth's criteria for enrollment in managed care plans and are not enrolled in a MassHealth managed care organization (MCO) are enrolled with MassHealth's Behavioral Health Program for the purpose of managing the delivery of mental health or substance abuse treatment services the member may require. Behavioral health services for members with a Behavioral Health Program restriction must be authorized by MassHealth's behavioral health contractor, and resulting claims must be billed to the Behavioral Health Program vendor.

Medical services provided to members with a Behavioral Health Program restriction, except those services listed as excluded services in 130 CMR 450.118(I), and laboratory services as described below must be authorized by the member's PCC, if applicable. Medical services must be billed on a separate UB-04 from any behavioral health charges, and sent to MassHealth for processing.

Laboratory services provided as part of a behavioral health treatment (diagnosis code range 290.00-316.99) must be billed directly to MassHealth. Laboratory services, when provided as part of a behavioral health treatment, do not require authorization from the member's PCC. Network providers may leave Item 63B blank when billing for laboratory services provided as part of a behavioral health treatment or diagnosis. Non-network providers must enter the pay-to-provider number of the behavioral health treatment provider requesting the laboratory work in Item 63B.

Acute Inpatient and Acute Outpatient Services Provided on the Same Day

During an Acute Inpatient Hospital Stay

Outpatient services provided to a member during the course of an inpatient hospitalization, whether at the same or a different facility, are not payable to the acute outpatient hospital. Acute hospitals may include these outpatient charges on an inpatient claim form.

On Day of Discharge

Outpatient services provided to a member on his or her date of discharge from an inpatient hospital, whether at the same or a different facility, must be billed by the outpatient facility on a UB-04 claim form. The outpatient claim form must include the outpatient provider's NPI in Item 56.

On the Day of Admission to a Different Facility

Acute outpatient services provided to a member on his or her date of admission to a different inpatient facility, but before the member's inpatient admission, must be billed by the outpatient facility on a UB-04 claim form. The outpatient claim form must include the outpatient provider's NPI number in Item 56, and the admission hour in Item 13.

Acute outpatient services provided to a member already admitted to an inpatient hospital are not payable to the outpatient hospital and must be billed as described above.

On the Day of Admission to the Same Facility

There is no separate reimbursement for emergency or acute outpatient services that result in a member's admission to the same hospital's inpatient facility on the same date. Acute hospitals may include these outpatient charges on an inpatient claim form.

When an **overnight** admission results from ambulatory surgery, or a procedure, the overnight stay must be billed as a transfer per diem on the inpatient claim.

Additional Instructions (cont.)

Services Provided to Newborns

Member ID Must Be Assigned to Newborns

All claims for MassHealth members, including newborns, must be submitted under the member's unique 10-character member identification number. Claims for services provided to newborns must not be submitted until the newborn has been assigned a member ID number. A claim for any service provided to the mother must be submitted on a separate claim from a claim for any service provided to the newborn.

Hospital Where Child Was Born Must Submit NOB-1 Form

To expedite eligibility determination and assignment of the member ID number for the newborn child of a MassHealth member, the hospital in which the birth occurred must complete and submit a Notification of Birth form (NOB-1) to the following address.

MassHealth Enrollment Center
ATTN: NOB Unit
300 Ocean Avenue, Suite 4000
Revere, MA 02151

Obtaining Newborn's RID After Eligibility Is Determined

Outpatient departments providing services to a newborn should ask the hospital in which the child was born to submit the NOB-1 form and upon return of the form, inform the outpatient department of the eligibility determination and assigned RID. The eligibility determination should take no longer than 30 days. To inquire about a newborn's eligibility after 30 days, call MassHealth Customer Service or the mother's local MassHealth Enrollment Center.

Code Sets for the UB-04 Claim Form

Item 4: Type of Bill

This three-digit code identifies the type of facility, bill classification, and frequency.

Acute Inpatient, Psychiatric Inpatien,t and Chronic Disease and Rehabilitation Inpatient Hospitals

111 - Admit-through-discharge claim
This bill is expected to be the only bill received for an inpatient hospitalization or course of treatment, including those claims representing a total hospitalization or course of treatment and those representing an entire benefit period of health insurance.

112 - Interim-first claim
This bill is the first in a series of bills for the same hospitalization or course of treatment.

113 - Interim-continuing claim
This bill is for continuing days during the same hospitalization or course of treatment. It is expected that further bills for this same hospitalization or course of treatment will be submitted.

114 - Interim-last claim
This bill is the last of a series of bills for which payment is expected for the same hospitalization or course of treatment. (Do not use this code in place of a code for late charges, adjustments, or zero/nonpayment claims.)

115 - Late-charges-only claim
This bill is for charges incurred by the provider after the claim covering all charges from admission through discharge has been submitted. Do not use this code in place of an adjustment. Do not include room-and-board charges on a claim for late charges.

Acute Outpatient and Chronic Disease and Rehabilitation Outpatient Hospitals

131 - All outpatient claims (except late charges)
135 - Late charges (not allowed for ambulatory surgery charges)
831 - Ambulatory surgical center (ASC) claims

Code Sets for the UB-04 Claim Form (cont.)

Item 13: Admission/Discharge Hour

00 - Midnight to 12:59 A.M.
01 - 1:00 A.M. to 1:59 A.M.
02 - 2:00 A.M. to 2:59 A.M.
03 - 3:00 A.M. to 3:59 A.M.
04 - 4:00 A.M. to 4:59 A.M.
05 - 5:00 A.M. to 5:59 A.M.
06 - 6:00 A.M. to 6:59 A.M.
07 - 7:00 A.M. to 7:59 A.M.
08 - 8:00 A.M. to 8:59 A.M.
09 - 9:00 A.M. to 9:59 A.M.
10 - 10:00 A.M. to 10:59 A.M.
11 - 11:00 A.M. to 11:59 A.M.
12 - Noon to 12:59 P.M.
13 - 1:00 P.M to 1:59 P.M.
14 - 2:00 P.M to 2:59 P.M.
15 - 3:00 P.M to 3:59 P.M.
16 - 4:00 P.M to 4:59 P.M.
17 - 5:00 P.M to 5:59 P.M.
18 - 6:00 P.M to 6:59 P.M.
19 - 7:00 P.M to 7:59 P.M.
20 - 8:00 P.M to 8:59 P.M
21 - 9:00 P.M to 9:59 P.M.
22 - 10:00 P.M to 10:59 P.M
23 - 11:00 P.M to 11:59 P.M.

Item 14: Admission Type

1 - Emergency
The patient requires immediate medical intervention as a result of severe, life-threatening, or potentially disabling conditions. Generally, the patient is admitted through the emergency room department.

2 - Urgent
The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation.

3 - Elective
The patient's condition permits adequate time to schedule the services.

4 - Newborn
The member is a baby born within this facility on the admission date in Item 17. Use of this code necessitates the use of special Source of Admission codes.

Item 15: Admission Source

Codes for Members Who Are Not Newborns

1 - Physician referral
The admission was made upon the recommendation of the patient's personal physician.

2 - Clinic referral
The patient was admitted to this facility upon the recommendation of this facility's clinic physician.

3 - HMO or MCO referral
The patient was admitted to this facility upon the recommendation of a health maintenance organization (HMO) physician or managed care organization (MCO).

4 - Transfer from a hospital
The patient was admitted to this facility as a transfer from an acute-care facility as an inpatient.

5 - Transfer from a skilled-nursing facility
The patient was admitted to this facility as a transfer from a skilled-nursing facility as an inpatient.

6 - Transfer from another health facility
The patient was admitted to this facility as a transfer from a health-care facility other than an acute-care facility or a skilled-nursing facility.

Code Sets for the UB-04 Claim Form (cont.)

7 - Emergency department
The patient was admitted to this facility upon the recommendation of this facility's emergency department physician.

8 - Court/law enforcement
The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law-enforcement agency representative.

9 - Information not available
The means by which the patient was admitted to this hospital are not known.

Newborn Codes

1 - Normal delivery
A baby was delivered without complications.

2 - Premature delivery
A baby was delivered with time or weight factors qualifying it for premature status.

3 - Sick baby
A baby was delivered with medical complications other than those relating to premature status.

4 - Extramural birth
A baby was delivered in a non-sterile environment.

9 - Information not available
The means by which the baby was delivered are not known.

Item 17: Patient Status

01 - Discharged to home or self-care (routine discharge)
02 - Discharged or transferred to another short-term general hospital
03 - Discharged or transferred to a skilled-nursing facility (SNF)
04 - Discharged or transferred to an intermediate-care facility (ICF)
06 - Discharged or transferred to home under care of organized home health agency
07 - Left against medical advice
10 - Discharged to a chronic disease and rehabilitation hospital
11 - Discharged to a mental health hospital
12 - Discharged to a rest home
13 - Discharged to a DMR residential facility
14 - Discharged to an ICF/MR state school
15 - Discharged to a community residence
16 - Transferred from medical-necessity to administrative-day status
17 - Transferred from administrative-day to medical-necessity status
18 - Discharged to leave of absence
21 - Deceased
30 - Still a patient

Items 18-25: Condition Codes

A1 - EPSDT
Physical and mental health assessments provided to members under age 21 to carry out the screening provisions of Early and Periodic Screening, Diagnosis and Treatment.

A4 - Family planning
Claim includes medically approved services provided to an individual of childbearing age for the purpose of enabling that individual to determine freely the number and spacing of her or his children.

Code Sets for the UB-04 Claim Form (cont.)

A7 - Induced abortion; danger to life
Claim includes charges for an abortion performed because the life of the member would have been endangered if her pregnancy had been carried to term.

Z1 - Induced abortion; other medically necessary reason
Claim includes charges for an abortion performed for medically necessary reasons other than danger to the member's life.

Z2 - Sterilization primary reason for hospitalization
Claim includes charges for sterilization when sterilization was the primary reason for this hospitalization.

Z3 - Sterilization not primary reason for hospitalization
Claim includes charges for sterilization when sterilization was not the primary reason for this hospitalization.

Z5 - School-based health center
Claim includes services provided at a school-based health center site that is operated by the outpatient hospital provider.

02 - Condition is employment related
Patient alleges that medical condition is due to environment/events resulting from employment.

05 - Lien has been filed
Provider has filed legal claim for recovery of funds potentially due a patient as the result of legal action initiated by or on behalf of the patient.

36 – General-care patient in a special unit
Patient temporarily placed in a special-care-unit bed because no general-care beds were available.

37 - Ward accommodation at patient request
Patient assigned to ward accommodations at the patient's request.

38 - Semi-private room not available
Either private or ward accommodations were assigned because semi-private accommodations were not available.

39 - Private room medically necessary
Patient needs a private room for medical requirements.

40 - Same day transfer
Patient was transferred to another facility before midnight on the day of admission.

Items 31-34: Occurrence Codes and Dates

01 - Auto accident
02 - Auto accident/no-fault
03 - Accident/tort liability
04 - Accident/employment-related
05 - Other accident
06 - Crime victim

Code Sets for the UB-04 Claim Form (cont.)

Item 39-40: Value Codes Acute Inpatient Hospital

For In-State Acute Admissions

22 - Member spenddown
Xl - Standard payment amount per discharge (acute stay 20 days or less)
X2 - Pediatric payment amount per discharge (pediatric unit stay 20 days or less)
X3 - Standard outlier per diem (per diem beginning with the 21st day)
X4 - Pediatric outlier per diem (pediatric unit per diem beginning with the 21st day of stay.)
X5 - Transfer per diem
X7 - Pediatric transfer per diem
X9 - Acute zero payment per diem
Yl - Nursing-facility administrative days (AD) or ICF-level AD for MassHealth member with Medicare Parts A and B, or Part B only
Y2 - Nursing-facility AD or ICF-level AD for MassHealth member without Medicare at all, or with Medicare Part A only
Y4 - Psychiatric per diem
Y7 - DMH replacement unit beds

For Out-of-State Acute Admissions

Z0 - Inpatient percentage of charge
Z3 - Inpatient per diem, non-administrative day patient

Item 39-40: Value Codes Outpatient Hospital

Y3 – Outpatient Hospital

Item 39-40: Value Codes Chronic Disease & Rehabilitation Inpatient Hospital

13 – Non-state-owned chronic/rehabilitation hospital level
14 – Non-state-owned chronic/rehabilitation AD
23 – Patient-paid amount
91 – State-owned chronic/rehabilitation hospital level
92 – State-owned chronic/rehabilitation NF AD
93 – State-owned chronic/rehabilitation AD

Item 39-40: Value Codes (Psychiatric)

16 - Psychiatric hospital per diem rate
17 - Psychiatric hospital administrative day rate
80 - Psychiatric hospital percentage of charge

Code Sets for the UB-04 Claim Form (cont.)

Item 42: Revenue Codes

Listed below, in alphabetical order by category, are the first two digits of the revenue codes used for hospital billing. This three-digit code identifies a specific accommodation, ancillary service, or billing calculation. Refer to the subcategories below to complete the appropriate revenue code. Incomplete revenue codes are not acceptable.

Section	Category	Section	Category
Ambulatory surgical care	49x	Nursery	17x
Anesthesia	37x	Occupational therapy	43x
Audiology	47x	Oncology	28x
Blood storage and processing	39x	Operating room	36x
Blood	38x	Organ acquisition	81x
Cardiology	48x	Organ donor bank	89x
Cast room	70x	Osteopathic services	53x
Clinic	51x	Outpatient services	50x
Coronary care	21x	Pathology services	31x
CT scan	35x	Pharmacy	25x
Diagnostic services	92x	Physical therapy	42x
Durable medical Equipment	29x	Professional fees	96x, 97x, 98x
EEG	74x	Psychiatric/psychological Services	91x
EKG/ECG	73x	Psychiatric/psychological treatment	90x
Emergency room	45x	Pulmonary function	46x
Gastro-intestinal services	75x	Radiology diagnostic	32x
Imaging services	40x	Radiology supplies	62x
Incremental nursing charge	23x	Radiology therapeutic	33x
Intensive care	20x	Recovery room	71x
IV therapy	26x	Renal dialysis	80x
Kidney acquisition	86x	Respiratory services	41x
Labor room/delivery	72x	Room/board	11x, 12x, 13x, 14x, 15x, 16x
Laboratory	30x		
Leave of absence	18x	Special charges	22x
Lithotripsy	79x	Speech pathology	44x
Medical/surgical supplies	27x	Therapeutic services	94x
MRI	61x	Total charge	001
Nuclear medicine	34x	Treatment room	76x

For additional information on the description of the revenue codes, please refer to the National Uniform Billing Instructions manual.

Code Sets for the UB-04 Claim Form (cont.)

Item 42: Revenue Codes (cont.)

Revenue codes marked with an asterisk (*) indicate that the code requires the entry of the number of units in Item 46. See code sets for Units of Service for a listing of revenue codes that require units.

11x Room and Board

*110 General classification
*111 Medical/surgical/GYN
*112 Obstetric
*113 Pediatric
*114 Psychiatric
*115 Hospice
*116 Detoxification
*117 Oncology
*119 Other

12x Room and Board

*120 General classification
*121 Medical/surgical/GYN
*122 Obstetric
*123 Pediatric
*124 Psychiatric
*125 Hospice
*126 Detoxification
*127 Oncology
*129 Other

13x Semi Private

*130 General classification
*131 Medical/surgical/GYN
*132 Obstetric
*133 Pediatric
*134 Psychiatric
*135 Hospice
*136 Detoxification
*137 Oncology
*139 Other

15x Room

*150 General classification
*151 Medical/surgical/GYN
*152 Obstetric
*153 Pediatric
*154 Psychiatric
*155 Hospice
*156 Detoxification
*159 Other

16x Other Room and Board

*160 General classification
*164 Sterile environment
*167 Self care
*169 Other

17x Nursery

*170 General classification
*171 Newborn
*172 Premature
*175 Neonatal ICU

18x Leave of Absence

180 General classification
182 Patient convenience
183 Therapeutic
184 ICF/MR-any reason
185 Nursing home for hospital
189 Other

20x Intensive Care

*200 General classification
*201 Surgical
*202 Medical
*203 Pediatric
*204 Psychiatric
*206 Post-ICU
*207 Burn care
*208 Trauma
*209 Intensive care

21x Coronary Care

*210 General classification
*211 Myocardial infarction
*212 Pulmonary care
*213 Heart transplant
*214 Post CCU
*219 Other coronary care

Code Sets for the UB-04 Claim Form (cont.)

Item 42: Revenue Codes (cont.)

22x Special Charges

220 General classification
221 Admission charge
222 Technical support charge
223 UR service charge
224 Late discharge medically necessary
229 Other special charges

23x Incremental Nursing Charge Rate

230 General classification
231 Nursery
232 Obstetric
233 ICU
234 CCU
235 Hospice
239 Other

25x Pharmacy

250 General classification
251 Generic drugs
252 Non-generic drugs
253 Take-home drugs
254 Drugs for other diagnostic services
255 Drugs incident to radiology
257 Non-prescription
258 IV solutions
259 Other pharmacy

26x IV Therapy

260 General classification
261 IV therapy–infusion pump
262 IV therapy–pharmacy service
264 IV therapy–supplies
269 IV therapy–other

27x Medical/Surgical Supplies and Devices

270 General classification
271 Non-sterile supply
272 Sterile supply
273 Take-home supplies
274 Prosthetic/orthotic devices
275 Pacemaker
276 Intraocular lens
277 Oxygen take home
278 Other implants
279 Other supplies/devices

28x Oncology

280 Oncology
289 Other oncology-related services

29x Durable Medical Equipment (Other Than Renal)

290 General classification
291 Rental
292 Purchase
293 Used
299 Other medical equipment

30x Laboratory

300 General classification
301 Chemistry
302 Immunology
303 Renal patient (home)
304 Non-routine dialysis
305 Hematology
306 Bacteriology-microbiology
307 Urology
309 Other laboratory

31x Pathology Services

310 General classification
311 Cytology
312 Histology
314 Biopsy
319 Other

32x Radiology-Diagnostic

320 General classification
321 Angiocardiology
322 Arthrography
323 Arteriography
324 Chest Xray
329 Other

33x Radiology-Therapeutic

330 General classification
331 Chemotherapy–injected
332 Chemotherapy–oral
333 Radiation therapy
335 Chemotherapy–IV
339 Other

Code Sets for the UB-04 Claim Form (cont.)

Item 42: Revenue Codes (cont.)

34x Nuclear medicine

340 General classification
341 Diagnostic
342 Therapeutic
349 Other

35x CT Scan

*350 General classification
*351 Head scan
*352 Body scan
*359 Other CT scan

36x Operating Room Services

360 General classification
361 Minor surgery
362 Organ transplant other than kidney
367 Kidney transplant
369 Other operating room services

37x Anesthesia

370 General classification
371 Incident to radiology
374 Acupuncture
379 Other anesthesia

38x Blood

380 Blood general
381 Packed red blood cells
383 Blood plasma
384 Blood platelets
385 Blood leucocytes
386 Blood other components
387 Cypoprecipitates
389 Blood–other

39x Blood Storage and Processing

390 General classification
391 Blood administration
399 Other blood storage and processing

40x Other Imaging Services

400 General classification
401 Mammography (diagnostic)
402 Ultrasound
403 Screening mammography
404 Positron emission tomography
409 Other imaging services

41x Respiratory Services

*410 General classification
*412 Inhalation services
*413 Hyperbaric oxygen therapy
*419 Other respiratory

42x Physical Therapy

*420 General classification
*421 Physical therapy- visit charge
*422 PT–hourly charge
*423 PT–group rate
*424 PT–Evaluation or reevaluation
*429 Other physical therapy

43x Occupational Therapy

*430 General classification
*431 Occupational therapy visit charge
*432 OT–hourly charge
*433 OT–group
*434 OT–evaluation and reevaluation
*439 Other occupational therapy

44x Speech-language pathology

*440 General classification
*441 S-L visit charge
*442 S-L hourly
*443 S-L group
*444 S-L evaluation or reevaluation
*449 Other speech-language pathology
45x Emergency room
*450 General classification
*459 Other emergency room

Code Sets for the UB-04 Claim Form (cont.)

Item 42: Revenue Codes (cont.)

46x Pulmonary function

460 General classification
469 Other pulmonary function

47x Audiology

470 General classification
471 Diagnosis
472 Treatment
479 Other audiology

48x Cardiology

480 General classification
481 Cardiac catheterization lab
482 Stress test
489 Other cardiology

49x Ambulatory

490 General classification
499 Other ambulatory surgical care

50x Outpatient Services

500 General classification
509 Other outpatient

51x Clinic

*510 General classification
*511 Chronic pain center
*512 Dental clinic
*519 Other clinic

53x Osteopathic Services

*530 General classification
*531 Osteopathic therapy
*539 Other osteopathic services

54x Ambulance

540 General classification
541 Supplies
542 Medical transport
543 Heart mobile
544 Oxygen
545 Air ambulance
546 Neonatal ambulance service
547 Pharmacy
548 Telephone transmission EKG
549 Other ambulance

57x Home Health Services

570 General classification
571 Visit charge
572 Hourly home health aide
579 Other home health aide

58x Other Home Health Visits

580 General classification
581 Visit charge
582 Hourly charge
589 Other home health visits

61x Magnetic Resonance Imaging (MRI)

610 MRI–General
611 MRI–Brain
612 MRI–Spinal cord
619 MRI–Other

62x Medical/Surgical Supplies-Extension of 27x

621 Supplies incident to radiology
622 Supplies incident to other diagnostic services

63x Drugs Requiring ID

630 EOP, Dialysis
634 Erythropoietin (EPO) <10,000 units
635 EPO ≥ 10,000 units
636 Drugs require detail code
639 Other drugs requiring ID

Code Sets for the UB-04 Claim Form (cont.)

Item 42: Revenue Codes (cont.)

70x Cast-Room Services

700 General classification
709 Other cast-room services

71x Recovery-Room Services

710 General classification
719 Other recovery room

72x Labor and Delivery-Room Charges

720 General classification
721 Labor-room services
722 Delivery-room services
723 Circumcision
724 Birthing-center services
729 Other labor-room/delivery-room services

73x EKG/EGG (Electrocardiogram)

730 General classification
731 Holter monitor
732 Telemetry
739 Other EKG/ECG

74x EEG (Electroencephalogram)

740 General classification
749 Other EEG

75x Gastrointestinal Services

750 General classification
759 Other gastrointestinal

76x Treatment Room or Observation

761 Treatment room
762 Observation room

79x Lithotripsy

790 General classification
799 Other lithotripsy

80x Renal Dialysis

800 General classification
*801 Inpatient hemodialysis
*802 Inpatient peritoneal dialysis (non-CAPD)
*803 Inpatient continuous ambulatory peritoneal dialysis (CAPD)
*804 Inpatient continuous cycling periodontal dialysis (CCPD)
809 Other inpatient dialysis

81x Organ Acquisition

810 General classification
811 Living donor–kidney
812 Cadaver donor–kidney
813 Unknown donor–kidney
814 Other kidney acquisition
815 Cadaver donor–heart
816 Other heart acquisition
817 Donor–liver
819 Other organ acquisition

82x Hemodialysis: Outpatient or Home

820 General classification
821 Hemodialysis (composite or other rate)
822 Home supplies
823 Home equipment
824 Maintenance (100%)
825 Support services
826 Home dialysis supplies
827 Home dialysis support services
829 Hemodialysis

83x Peritoneal Dialysis: Outpatient or Home

830 General classification
831 Peritoneal (composite or other rate)
832 Home supplies
833 Home equipment
834 Maintenance (100%)
835 Support services
839 Other outpatient peritoneal dialysis

Code Sets for the UB-04 Claim Form (cont.)

Item 42: Revenue Codes (cont.)

84x Continuous Ambulatory Peritoneal Dialysis (CAPD): Outpatient or Home

840 General classification
841 CAPD composite/other
842 Home supplies
843 Home equipment
844 Maintenance (100%)
845 Support services
849 Other outpatient CAPD

85x Continuous Cycling Peritoneal Dialysis (CCPD): Outpatient or Home

850 General classification
851 CCPD composite/other rate
852 Home supplies
853 Home equipment
854 Maintenance (100%)
855 Support services
859 Other outpatient CCPD

86x Kidney Acquisition

860 General classification
861 Monozygotic sibling
862 Dizygotic sibling
863 Genetic parent
864 Child
865 Non-related living
866 Cadaver

87x Home Dialysis Program-Continuous Ambulatory Peritoneal Dialysis (CAPD)

870 General classification
875 Delivery charges
876 Supplies
877 Support services
878 Target rate program

88x Miscellaneous Dialysis Services

880 General classification
889 Miscellaneous dialysis service/other
881 Ultrafiltration
882 Home dialysis aid visit

90x Psychiatric/Psychological Treatment

900 General classification
901 Electroshock treatment
902 Milieu therapy
903 Play therapy
909 Other

91x Psychiatric/Psychological Services

910 General classification
911 Rehabilitation
914 Individual therapy
915 Group therapy
916 Family therapy
917 Biofeedback
918 Testing
919 Other

92x Diagnostic Services

*920 General classification
921 Peripheral vascular lab
922 Electromyogram
923 Pap smear
924 Allergy test
925 Pregnancy test
926 Other diagnostic service
927 General classification
*929 Peripheral vascular lab

89x Other Donor Bank

890 General classification
891 Bone
892 Organ
893 Skin
899 Other donor bank

94x Therapeutic Services

*940 General classification
*941 Recreational therapy
942 Education/training
943 Cardiac rehabilitation
944 Drug rehabilitation
945 Alcohol rehabilitation
946 Complex medical equipment
947 Complex medical equipment ancillary
949 Other therapeutic services

Code Sets for the UB-04 Claim Form (cont.)

Item 42: Revenue Codes (cont.)

96x Professional Fees

960 General classification
961 Psychiatric
962 Ophthalmology
963 Anesthesiologist (MD)
964 Anesthetist (RN)
969 Other professional fees

97x Professional Fees

971 Laboratory
972 Radiology–diagnostic
973 Radiology–therapeutic
974 Radiology–nuclear med.
975 Operating room
976 Respiratory therapy
977 Physical therapy
978 Occupational therapy
979 Speech pathology

98x Professional Fees

981 Emergency room
982 Outpatient services
983 Clinic
985 EKG
986 EEG
987 Hospital visit
988 Consultation

Item 46: Units of Service

A unit is required for the following revenue codes. The type of unit (for example, number of days) is also indicated.

Revenue Code	Units
11x	number of days
12x	number of days
13x	number of days
15x	number of days
16x	number of days
17x	number of days
18x	number of days
20x	number of days
21x	number of days
35x	number of sessions
41x	number of days
42x	number of days
43x	number of days
44x	number of days
45x	number of days
51x	number of days
53x	number of days
801 through 804	number of days
92x	number of days
94x	number of days

Example: A semi-private, two-bed, pediatric room during a five-day stay is entered as follows.

Revenue Code	Units
123	5